Health Services for Migrant Farm Families*

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MIGRATION has been part of the pattern of American life throughout the history of this country. As the frontiers were pushed westward, people over and over again moved their families and their possessions to new areas in which they settled and developed their economic and community life. This movement, that of the pioneers, was a migration which had as its stimulus the increased opportunities occasioned by development of a rich and fertile country—opportunities which were constantly present so long as the frontiers remained.

The migration of peoples in the United States has not ceased, but in the later development of our economic life it has changed markedly in character. This paper is concerned with one broad aspect of the general problem of migration in recent years—the problem of migratory agricultural people. The clear-cut trend toward the development of large land holdings, the increasing use of farm machinery, and the impoverishment of agricultural people in many sections of the country, due to depletion and erosion of the soil, have served to create an unrooted, shifting population of dispossessed farm people who move through the cycle of farm ownership to tenancy, to share-cropping, and finally to agricultural labor.

The nation was little aware of the vast problem which was developing throughout the land, and which by the 1930's had assumed relatively vast proportions. Though in urban centers large masses of unemployed and impoverished people are easily discerned because of their concentration, an equal number of such people, where highly mobile and scattered over sparsely settled rural areas, are not readily apparent to the unpractised eye. The movement of such peoples from one area of employment to another throughout the greater part of the year, their concentration in miserable shelters on the outskirts of towns, and their long hours of work in the field during the day tend to keep them out of sight and to make the problem of their existence much less apparent to the average busy citizen.

The Grapes of Wrath, through its penetrating study of the Joad family, served to dramatize the problems of migratory farm workers so vitally that the reading public was rudely shocked. Studies by the Tolan and La Follette Committees and Carey McWilliams' factual book *Factories in the Field* backed up with hard facts and cold figures the fictional version set forth by John Steinbeck.

Here were people presenting problems of housing, nutrition, and medical services—approximately two million of them—lacking the barest necessities we feel essential to a decent existence in

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our social structure. Today the extensive program of public health and medical care that is being carried on by the Office of Labor of the War Food Administration, as a wartime agricultural man power measure, represents an outgrowth of the work started by the Farm Security Administration in the 1930's to meet these problems of migratory farm families.

Late in 1935, a camp for migratory farm families was opened in Arvin, Calif., by the Federal Emergency Relief Administration. This camp was transferred early in 1936 to the Farm Security Administration which, at about the same time, constructed and opened the camp at Marysville, Calif. These camps were the forerunners of a growing number of federal camps for farm workers, which have come to number about 250. The earliest camps, those developed first in California and Arizona, then in the Pacific Northwest, and later in Texas and Florida, could of course care for only a small minority of migratory farm families in those areas, but they were vastly important in developing patterns by which the problems of migrants could be attacked. Some of the camps were of permanent construction, whereas others were "mobile," suited to the needs of seasonal workers following the crops. They were constructed to provide minimum decent housing, good sanitation, and community and recreational services. The families were encouraged to take part in the administration and maintenance of the camps by participating in elected camp councils, working in coöperation with the camp manager and his staff.

It must be remembered that in a majority of instances these people were ineligible for local relief and medical services because their mobility made them, for the most part, nonresidents under the various residency laws of the states. Time does not permit a discussion of the numerous problems of ill health among these migrants which were not being met even to the smallest degree. Serious illness and malnutrition among them were increasingly reported. The fear of serious epidemics was ever present. Public health authorities were turning increasing attention to the problem, but the desperate need for medical and dental services remained.

A plan to administer federal aid in coöperation with the California State Relief Administration was soon superseded when it was decided that relief furnished to transients by the Farm Security Administration through its facilities should include medical care. Prepayment plans such as those sponsored by the Farm Security Administration among low-income farm families were not adaptable to meet the needs of migrants, for there was not only a constantly shifting population to deal with, but one unable to purchase medical care through its own resources even on the prepayment basis. Payment for medical care for these migrants through use of individual grants, moreover, was not workable, because of the high mobility of the families. Accordingly, an interesting mechanism was set up in coöperation with the State Health Department, the State Relief Administration, and the State Medical and Dental Associations. A corporation was organized known as the Agricultural Workers Health and Medical Association, a nonprofit association financed by grants of funds from the Farm Security Administration. The association could engage in any activities related to the provision of medical and dental services, nursing, and hospitalization. As camps were established in other regions, similar medical care corporations were organized to provide services for medically indigent migratory farm families.

During these pre-war years, regional health programs were directed by Farm

Security Administration medical officers who, with their staffs, supervised general health and sanitation work in their regions and served also as medical advisers to the agricultural workers' health associations. Each association, operating through a board of directors including representatives of professional societies, public health agencies, and general public and agricultural interests, contracted with local practitioners and institutions to render needed services to farm workers and their families.

Services were rendered chiefly through health centers or clinics set up in government farm labor camps and at other points of farm labor concentration, in the charge, usually, of a full-time nurse. Local health departments coöperated in holding various public health clinics and conferences in these health centers. Therapeutic services were rendered by local private physicians or dentists at appointed clinic hours, or, when serious complaints were presented between clinic hours, by referrals to their private offices. Hospitalization was of course provided when necessary, and services even extended to the provision of special diets in cases of malnutrition.

This, then, was the general pattern which had been developed when the war came in 1941. The war was to bring very drastic changes in the national farm labor picture, but the general pattern for providing health services was to prove its worth under new conditions. As large numbers of agricultural workers migrated to the cities in search of more lucrative work in war industries, it became quickly apparent that there would be a shortage of agricultural labor. In 1942 the production of food seemed seriously menaced by the shortage of workers. Emergency funds available to the President were used to bring several thousand Mexican farm workers into the United States and to transport some of our own workers to points of acute labor shortage.

In the spring of 1943 an act was passed by the Congress setting up an extensive program for the importation of farm workers from other countries, chiefly Mexico and the West Indies, and the mobilization of available farm labor within the United States. Under the international agreements and in accordance with the act adopted by the Congress, the workers imported and transported under this program have been entitled to receive medical care and health services without cost to themselves. Under the Office of Labor of the War Food Administration, the pattern for providing health services which had originally been developed by the Farm Security Administration has been maintained and expanded to meet the needs of all farm workers under War Food Administration jurisdiction.

During this past year the health program has been carried out largely through six agricultural workers' health associations which cover from four to twelve states each. Each operates under a contract with the War Food Administration, whereby the association is paid by the federal government for the services it renders foreign and migratory workers. The associations represent practical coöperation between government and organized professional groups, and they have encountered little difficulty in enlisting the support of local physicians, dentists, and hospitals. The flexible association mechanism lends itself to fast action in a rapidly moving program built around a highly mobile population. Informal agreements can be reached with local doctors and dentists on short notice; nurses can be employed on the spot; drugs and supplies can be purchased in the open market; and bills can be paid the day they are received.

As in pre-war times, the program has been carried out wherever possible

through clinics in the farm labor supply centers or at other points of farm labor concentration. Approximately 250 clinics are operated during the year, staffed by full-time or part-time nurses. Therapeutic services are provided by one or more local physicians serving at regular clinic hours each week and paid on a per hour basis. Arrangements are made for dental care either on a clinic basis or by referral to the offices of local dentists. A large volume of hospital care is provided, not only for acute conditions but for the correction or amelioration of chronic and disabling conditions affecting health and working efficiency. In two critical areas—in Florida and Arizona—special hospitals have been maintained for farm workers.

At certain points with critical shortages of physicians and dentists, commissioned officers of the U. S. Public Health Service have been used to furnish care. Aside from six medical and dental officers now actively serving in Connecticut, Florida, Idaho, and Washington, there are several full-time dentists engaged by agricultural workers' health associations to operate mobile dental clinics—a highly useful way to bring dental care to a maximum number of those needing it.

With regard to the highly important field of preventive services, the cooperation of state and local health departments is constantly enlisted. The policy is to utilize local health department facilities when they are accessible to the farm workers, or to invite local health department personnel to conduct clinics or health education programs in the facilities of the farm labor camps. Probably the chief province of coöperation this year has been in the control of venereal diseases. Even in this well established public health activity, however, local public health services are often lacking, and it is necessary for the clinic physician, engaged primarily for general therapeutic medical services, to conduct regular venereal disease clinics. Unfortunately in those very areas in which farm labor concentration runs high, local public health services are generally rather weak, so that the responsibility for preventive services falls chiefly on the personnel in this program.

The initial preventive measure, however, consists of recruitment medical examinations before workers are transported by the federal government. The task is not only to prevent the spread of communicable diseases across state or national boundaries, but also to assure the transportation of workers who will be physically capable of doing strenuous farm work.

In Mexico, for example, every worker is examined by a team of U. S. Public Health Service medical officers, who work in coöperation with Mexican physicians. In addition to a physical examination, an x-ray of the chest is performed and each worker is vaccinated against smallpox. Immunization for Rocky Mountain spotted fever is started in Mexico City and completed on the trains carrying workers to regions where this disease is prevalent. Certain of the defects found in these workers are correctible, and the worker is allowed to come through to this country after the defect is corrected. A laboratory for performing serologic tests for syphilis is being set up in Mexico City. Similar examinations have been done for Jamaicans, Bahamians, Barbadians, and Newfoundlanders. Somewhat less extensive recruitment examinations have been done for interstate migratory workers.

Once farm workers are placed in an area of employment, every effort is made to provide a complete program of preventive services. These have included mass immunizations, chest x-ray surveys for tuberculosis, lectures and discussions on health and personal hygiene, maternal and infant hygiene

clinics, planned nutrition, venereal disease control, environmental sanitation, and safety education and practice. In many places, isolation centers are maintained for cases of communicable disease. Food handlers are routinely inspected, and laboratory tests are performed to eliminate the possibility of food-borne epidemics. The problems of sanitation, particularly in the mobile camps, are tremendous, and constant vigilance is necessary to maintain sanitary facilities in a proper condition.

The predominance, since the onset of the war, of single male workers rather than families has lessened the need, to some degree, for maternal and infant services. Where families are still part of the seasonal farm labor population, however, as they are particularly in parts of Florida, Texas, and the Pacific Coast, well baby conferences are carried on, attended by local physicians, and complete prenatal and postpartum care is rendered. Regular clinics are held also for preschool children, and in a few places where nursery schools are operated, daily health inspections are part of the routine, and health education is an integral part of the school program. For teen-age girls, classes have been conducted in sex hygiene, developing their approach from matters of special interest to young women, such as cosmetic care of the skin.

Some of the camps maintain completely equipped delivery rooms where deliveries can be performed practically under hospital conditions. Where hospitals are locally available, however, maternity cases are usually hospitalized. The usual mother in a farm labor family has had experience with neither a hospital nor a physician during her previous pregnancies, and special problems are presented with respect to overcoming fears and superstitions which have been developed through experience with untrained midwives.

In all these activities, in both the therapeutic and the preventive aspects of the program, the field nurse is a key worker. With the coöperation of the manager in the farm labor camp in which she is stationed, clinics are organized and the workers are educated to use them at the first sign of illness. The task of establishing clinic hours convenient to the workers, in order to conserve their time and productive capacity, and at the same time convenient to the local physician, is often difficult. The nurse's intimate contact with the camp enables her to promote health education, to inspect sanitation and report needed improvements, and to act as a confidante to the workers whose distance from home often causes mild depressions or anxiety attacks. The nurse is furnished with a liberal set of standing orders, issued by the field medical officer and approved by the local clinic physician, to enable her to deal with minor ailments pending the attendance of the physician. Finally, the nurse is a natural liaison officer between the local health agencies, the local physicians, and the farm worker population.

This program costs the federal government about two million dollars annually, or from about $1.50 to $2.00 per eligible person per month. Costs vary markedly in different parts of the country and in accordance with the pattern of services. Thus, services rendered on a clinic basis with remuneration at a fixed rate per hour tend to be more economical than services rendered by referral to private offices, with payment being made on the basis of a fee-for-service schedule.

In the course of a year, over 150,000 farm workers and their dependents are involved in this program. Services may be provided only to certain specified categories of farm workers defined in the legislation passed by the Congress. The chief groups covered are farm

workers imported from foreign nations, inter-state transportees, and other migratory farm workers living in areas surrounding government farm labor supply centers to whom adequate medical services are not otherwise available. Our agency is proud of the fact that sickness absenteeism has, according to our records, been kept down to a loss of only 1.5 per cent of available man days, a rate which compares most favorably with the general industrial average throughout the country.

The end of the war will undoubtedly again change the farm labor situation. Importation of foreign workers will certainly be curtailed. Shut-down of war industries will release many families for migration back to the fields—in fact, evidences of this are already seen in California and the Pacific Northwest. Labor surpluses, if they exist, will once again mean the mass migration of agricultural workers from area to area. Increased use of farm machinery will bring with it a corresponding increase in the number of unemployed in agricultural labor.

We cannot and must not permit another "Grapes of Wrath." We must recognize that while we have agricultural migrants we face certain familiar problems. Migrants are people. They deserve a chance to live in decent housing, to feed and educate their children, to get needed health care for their families. A beginning has been made in the patterns developed in recent years, patterns of federal action supplementing services provided by the states. The lessons of experience must be translated into a really effective long-range program of health and welfare for our migrant farm families.

Summary of Discussion

Dr. John J. Sippy emphasized the great problems created for California because of the migration of labor into that state. He stated, however, that with more prosperous economic circumstances today, he believed that the migrants could afford to pay for their own medical services on a private basis and that there was, therefore, less need for federal subsidy to a medical care program. He stressed the importance of local health department responsibility in handling the problem of health services to migrant workers. Dr. Sippy pointed out that in San Joaquin County, where he was Health Officer, only a small portion of the total migrant population was located in federally operated camps, leaving a great majority housed on the premises of private growers.

Dr. Jessie M. Bierman pointed out that residence requirements for welfare department assistance ruled out aid to the migrant families. She stressed, however, that with regard to the preventive services rendered by health departments the same aid should be given as for local citizens. Dr. Bierman discussed the serious extent of the health needs of this group.

Dr. Myron E. Wegman raised the general question of the proper rôle of the health department in this entire program. Dr. Mott replied that the burden of care for this group should be shared by the states and the federal government, but he raised the further question on the proper proportions which should be assumed between the federal and state agencies. He pointed out that the cost for complete medical services to this group was relatively high, amounting to as much as $3.00 per person per month in the Pacific Coast states. The question was: Could this expenditure be borne by the states or local communities without federal assistance? Dr. Sippy reaffirmed his belief that the operation and financial support for this program should be entirely on a local basis. He claimed that the seriousness of the problem had been exaggerated by such books as *Grapes of Wrath*.

Katherine Baker stated that the problem of health services to migrant families was even greater than had been written about. She pointed out that little in the way of proper housing and sanitation on the premises of private farms could be expected when the owners of those farms, responsible for their maintenance, often lived thousands of miles away.

Question from the floor: Are any legal

difficulties encountered in organizing the non-profit organizations which provide health services to the migrants?

Dr. Mott answered that no insurmountable difficulties had been encountered.

Question: Do health departments play any part in the management of these corporations?

Dr. Mott answered that in California and elsewhere there were representatives of the health departments and the U. S. Public Health Service on the Boards of Directors of the corporations.

Question: Are medical records transferred from camp to camp when the migrants move?

Mrs. Baker answered by pointing out the numerous difficulties involved in the rapid transfer of records, indicating that this was a problem still to be solved adequately.

Question: Are health services rendered to day-haul children?

Dr. Bierman answered that no special health services were provided this group in California, and it was explained that they were not under the jurisdiction of the War Food Administration Office of Labor.

Question: Are health services provided by agricultural workers' health associations in agricultural youth camps?

Dr. Mott answered that he did not know of any, except possibly in Maine, pointing out that these camps were not under WFA Office of Labor jurisdiction.

Question: Is bedside nursing provided to the migrant families?

Mrs. Baker answered that as much bedside nursing was provided as there was time for.

Question: Are any school nursing services provided in this program?

Mrs. Baker answered that the children of migrant families received school nursing services through the regular school nurses in the local communities in which they might attend school. Nursing services are, however, provided in a few nursery schools operated under this program.

Professor Winslow Retires from Yale

Recent announcement has been made of the retirement of Professor C.-E. A. Winslow as Professor of Public Health at Yale University at the close of the current academic year, and of the appointment as his successor of Professor Ira V. Hiscock, now in active service in the Civil Affairs Division of the War Department. Professor Winslow has taught at Yale for thirty years. It is indicated that Yale University has decided to carry the work of his department forward along the same broad lines which he has laid out. For the A.P.H.A. this is largely a family affair, since Professor Winslow is a Past President of the Association, Past Chairman of the Committee on Administrative Practice, recipient of the Sedgwick Memorial Medal, and is at present editor of the *American Journal of Public Health* and chairman of the Committee on the Hygiene of Housing. Professor Hiscock has been fruitfully active in the work of the Committee on Administrative Practice and in the Health Education Section, and as the moving spirit of the Health Education Institutes. He is now a member of the Editorial Board of the *Journal.*